

Responses Submitted to the House Energy and Commerce Subcommittee on Oversight and Investigations, in follow-up to the Thursday, May 21 2015 hearing entitled “What are the State Governments Doing to Combat the Opioid Abuse Epidemic?”

The Honorable Tim Murphy, Chairman
The Honorable Diana DeGette, Ranking Member
2322 Rayburn House Office Building

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The Honorable Michael C. Burgess

- 1. Complaints regarding PDMPs suggest that these systems are not real time, not widely used, are time consuming and burdensome. In 2005, Congress enacted NASPER, with strong support from health care providers and broad, bipartisan support. However, the program has not been funded since 2010 and faced similar lack of funding prior to 2010. NASPER would provide assistance to allow PDMPs to meet consistent national criteria and allow for interoperability between state PDMPs. This is a question that I had previously asked of the CDC, due to their state monitoring efforts. However, I would like to hear the state perspective. Do you think that national criteria and standardized content would be beneficial in fostering a more attractive state-based PDMP network for providers?**

Colorado House Bill 14-1283- *Modifications to the Electronic Prescription Drug Monitoring Program*-amended Board of Pharmacy Rules, and with consolidated and cooperative efforts led by the Governor, we have made tremendous strides towards improving our PDMP from both an accessibility and technological standpoint. Our efforts have developed the Colorado PDMP to become more beneficial and usable to its prescribers and dispensers, and to align it with existing national criteria and standardized content. The recent modifications in Colorado include:

- Mandatory registration
- Allowing up to 3 delegates of a prescriber to access the PDMP on each prescriber’s behalf
- Requiring pharmacies to upload dispensing data on a daily basis (versus the historically twice per month uploading requirement)
- Allowing federally owned and operated pharmacies to submit data into the PDMP
- Providing “push notices” to affected prescribers and pharmacies when patients visit a certain number of prescribers and pharmacies over a specific time to seek a controlled substance
- Enhancing the overall interface of the PDMP itself to allow for easier use.

With these changes, Colorado has targeted many of the existing national criteria and standardized content in place. This nationally accepted criteria has ultimately made the PDMP more usable for providers as illustrated by both higher utilization rates and fewer push notices being sent from month-to-month using the identical threshold for the generation of such push notices. The two elements of accepted criteria that Colorado may benefit from, but are cost-prohibitive, include real-time reporting and integration of PDMP data with decision support tools in the electronic health record and health information exchanges. This would add benefits such as a single sign-on (as opposed to having to access separate database to obtain different pieces of information). These elements are also criteria that most states have not yet achieved.

2. Interoperable PDMPs would do much to decrease incidence of doctor shopping. What has been your experience with interstate accessibility of PDMPs? Are the current interstate data-sharing exchanges, such as the Prescription Drug Monitoring Program Interconnect effective?

Colorado's PDMP is currently connected with the PDMPs in 28 other states including neighboring states (except Wyoming) by way of an interconnect program (PMP InterConnect) run by the National Association of Boards of Pharmacy. NABP anticipates that 70% of the state PDMPs will be either connected to or working toward a connection in 2015. Currently, 29 states are participating in PMP InterConnect, with Iowa being the latest state to go live in May 2015. Several other states have signed memorandums of understanding to participate in the program. While Colorado currently has no concrete data regarding the effectiveness of such an interconnection, it likely should be assumed that interconnection would ultimately support existing state work to decrease the incidence of doctor shopping and would ensure standardized criteria is utilized.

3. It is my understanding that obstacles to managing opioid abuse epidemic vary widely from state to state, ranging from the stigma associated with medication assisted treatments to lack of adequate data, which is sometimes associated with the need for interoperable PDMPs. Could each of you discuss what you recognize as being the biggest obstacle towards controlling the opioid epidemic in your state? Do you think that the federal response to the opioid epidemic has been sufficient.

As expressed in our testimony, 2010-11 data revealed that Colorado had the troubling distinction of ranking 2nd nationally for self-reported, non-medical use of prescription drugs. Since that time we have been encouraged by 2013 data released by the National Survey on Drug Use and Health, showing that our rate of non-medical use has decreased from 6% to 5.08%, which represents 39,000 fewer Coloradans who misused prescription drugs during the survey time period (2011-12). This recent data suggest that we are well on track to meet expressed goals. Despite encouraging trends, prescription drug abuse remains a serious health crisis as we work to expand upon and bolster work currently underway in Colorado. As a state, we have a variety of distinctive characteristics and challenges that continually inform the *Colorado Plan to Reduce Prescription Drug Abuse*, including our geographic diversity and state and local governance structures, increasing heroin usage rates, access to quality treatment resources, and general funding limitations.

Colorado faces unique challenges given our geographic and population-density diversity. Communities across Colorado- whether large or small, rural or urban, on the Eastern Plains or the Western Slope- face varying opportunities and obstacles. In some areas, access to appropriate resources is inadequate, and specific areas of the state are disproportionately impacted by the prescription drug abuse epidemic. Additionally, Colorado has a state-supervised and county-administered human services system. Under this system, county departments are the primary provider of direct services (primarily behavioral health services) to Coloradans. This system plays an integral role as we formulate policies and strategies directed at the state level to be responsive to community specific needs. It is vitally important that we work closely with our county partners and communities as our strategic plan develops and adapts to new data and emerging best practice.

In the last five years, the number of Heroin users in Colorado has doubled, a rate increase we suspect has some correlation with our high rates of prescription drug misuse and abuse. Although available literature suggest that the misuse and abuse of prescription drugs is a risk factor for future heroin use, currently available data doesn't appear to support that a crack down on the supply of opioid pain relievers is the driver of recent increases in heroin use. We look forward to working with our federal counterparts to continue to collect data and monitor the relationship between heroin and prescription opioids so we can provide the most appropriate prevention, early intervention, referral, treatment and recovery strategies.

We also have significant concerns that existing treatment capacity is not meeting a rising demand, as treatment for heroin and prescription opioid abuse increased 128% between 2007 and 2014. Our state has long supported evidence-based practices in treating substance use disorders, including opioid medication assisted therapy (MAT), but we are concerned that the capacity has not risen fast enough to keep up with the increasing demand. Overdose death is a very real risk for people struggling with opiate addiction, and failure to provide vital treatment services means unnecessary, preventable deaths of our citizens. We would urge our federal counterparts to continue to explore avenues to increase access to treatment resources, specifically MAT services. Additionally, we support maintaining a strong commitment to the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an effective program supporting prevention, treatment, and recovery services.

While we applaud our federal counterparts in their leadership in prioritizing the prevention of prescription drug abuse, we can all agree that there is much work to be done. We look forward to continued partnership and collaboration.

The Honorable Tim Murphy

1. What are the pros and cons of giving someone Naloxone? What type of educational component should be directly linked to the expansion of this overdose reversal drug?

Fatal drug overdoses continue to be on the rise in Colorado, and the United States. Overdoses kill more people in the United States than car accidents. From 2000-2013, 8,802 Coloradans died from drug overdoses with opioids being a main factor in 2,875 of these deaths (Colorado Department of Public Health & Environment, 2014). While some of these deaths involve illegal drugs, many more involve prescription painkillers—drugs many of us have in our medicine cabinets. In most cases, these deaths are unintentional and could be prevented by the timely administration of Naloxone. This medication is used

in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. Naloxone is a nonscheduled (i.e., non-addictive), prescription medication, and only works if a person has opioids in their system; the medication has no effect if opioids are absent. As we work to expand access of Naloxone to laypersons in the community- where most overdoses are witnessed and can be immediately addressed- education and training is a critical component safe, effective use. For example, our educational efforts work to dispel any notion that administering Naloxone negates the importance of also contacting emergency medical services. Because this opioid antagonist is a temporary response that wears off in 20-90 minutes, additional medical intervention is most likely needed. Administering Naloxone could also highlight an underlying heart issue, or other medical condition, as the person is going into withdrawal.

Historically, only emergency department personnel and emergency medical services carried and administered this medication, and across the country access to opiate antagonists is often limited unnecessarily by laws that pre-date the overdose epidemic. To this end, Colorado has passed 3 statewide laws to reduce the harms associated with overdose. In 2012, Colorado passed the “Good Samaritan Law” (*SB 12-020*), to encourage witnesses to call for medical help during emergency overdose situations. The law provides limited legal protection from drug charges for those who call 911 for help. It also protects persons suffering an opiate overdose- rather than being arrested or prosecuted, they are referred to the proper treatment programs. In 2013, Colorado passed the “Third Party Naloxone Law” (*SB 13-014*), providing protection from criminal charges for medical professionals who prescribe Naloxone to third parties, and for non-medical people who witness an overdose and administer the drug. The law also protects healthcare professionals who administer Naloxone in an overdose emergency from charges. In 2015, Colorado passed “Standing Order” legislation (*SB 15-053*), extending existing authority to prescribe or dispense opiate antagonists by permitting licensed prescribers and licensed dispensers to also prescribe or dispense a standing order directly to individuals, a friend or family member or an individual who may experience an opiate-related drug overdose, an employee or volunteer of a harm reduction organization or a first responder. Licensed prescribers and licensed dispensers may prescribe or dispense permitted opiate-antagonist drugs in a good-faith effort.

In many cases, opioid antagonist medications can serve as our first line of defense in confronting this epidemic. Just this week, a local public health organization, the Harm Reduction Action Center, reported that Naloxone the organization has provided to the community has reversed 200 reported overdoses in the last three years. Recently, two police departments in Colorado started carrying Naloxone, with one reversal already reported. Denver Health and Hospital, Denver County's safety net hospital recently placed Naloxone on their formulary so any prescriber within their system can prescribe to their patients. With this policy change, anyone that comes in to their emergency department on an observation of an overdose, is discharged with a prescription for Naloxone that they can pick up on site. This type of resource is essential, especially for folks that do not identify as drug users and would not necessarily seek out such services.

Increasing awareness of and access to Naloxone through clinical, organizational, and public policy initiatives is critical component of our larger efforts to reduce prescription drug abuse throughout the state. Training interested providers, patients, and family members or friends on how to use and administer Naloxone is relatively easy; raising awareness of the need to have Naloxone readily available will require considerable effort.

The Honorable David McKinley

1. You spoke in great detail about the measures you have taken in Colorado to combat this epidemic. Please share any ideas that you have that we would be able to apply to West Virginia and across the country.

In addition to the specific areas of focus we articulated in our testimony, we would like to re-emphasize the importance of the Consortium for Prescription Drug Abuse Prevention (Consortium) model in our work to combat this epidemic. This cooperative, interagency/interuniversity framework is designed to facilitate the collaboration and implementation of the strategic plan by interested parties and agencies. The Consortium is housed in the University of Colorado (CU) Skaggs School of Pharmacy and Pharmaceutical Sciences at the Anschutz Medical Campus (which houses the School of Pharmacy, the Colorado School of Public Health, Colorado State University, the University of Northern Colorado, the CU School of Medicine, and the CU College of Nursing). The Consortium provides a statewide, inter-university/inter-agency network and serves as the strategic lead for the *Colorado Plan to Reduce Prescription Drug Abuse* with active participation from the Governor's Policy Office and relevant state agencies and engaged public and private partners. The educational, law-enforcement and medical communities are well positioned to address many of Colorado's key prescription drug abuse issues, and the partnerships facilitated by the Consortium are crucial in attaining optimum outcomes and increased federal funding to combat the growing problem. As the coordinating center, the Consortium houses each focus-area workgroup, co-chaired by an agency/community and university representative.

While the Consortium model specifically may not be the best fit for other states, we see enormous value in the establishment of a central entity that acts as a convener and medium for the varying disciplines and expertise areas so integral to executing a holistic, and multi-faceted response to this epidemic.